| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING 00<br>B. WING | 06/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST<br>NEW ALBANY, IN47150 |

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| F0000 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: June 13, 14, 15, 16, and 17, 2011<br><br>Facility number : 001145<br>Provider number: 155616<br>Aim number : 200120200<br><br>Survey team:<br>Gloria J. Reisert, MSW/TC<br>Dorothy Navetta RN<br>Avona Connell RN<br>Donna Groan RN<br><br>,<br>Census bed type:<br>SNF/NF: 66<br>Residential: 15<br>Total: 81<br><br>Census payor type:<br>Medicare: 10<br>Medicaid: 48<br>Other: 23<br>Total: 81<br><br>Sample: 15<br>Supplemental sample: 8<br>Residential sample : 7 | F0000 | **This plan of correction is to serve as Landmark Nursing & Rehabilitation Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Landmark Nursing & Rehabilitation Center or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review completed 6/21/11<br>Cathy Emswiller RN | | | |

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| F0157 SS=D | A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br>Based on record review and interview, the facility failed to ensure the physician was notified of a referral not being done for 1 of 1 resident with a referral to an orthopedic [ortho] doctor in a sample of 15. (Resident #56); and failed to notify the resident's physician and ENT [ear, nose and throat] specialist when the | F0157 | I. An Ortho consult for R56 was discontinued per his primary physician. On June , 2011 R51's primary physician and ENT were notified of referral to oral surgeon. II. All residents with specialty referrals are at risk to be affected. All resident records were reviewed and no outstanding referrals were noted. | 07/16/2011 |

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| | consultant dentist made a recommendation for evaluation of an irregular area noted to the resident's tongue. This deficient practice affected 1 of 1 resident reviewed for dental referral in a sample of 15 residents. (Resident #51)<br><br>Findings include:<br><br>1. The clinical record for Resident #56 was reviewed on 6/14/11 at 1:25 p.m. The resident's diagnoses included, but were not limited to, below knee amputation and fracture distal second, third, fourth, and fifth metatarsals of uncertain age. The resident had an X-ray of the right foot completed on 5/24/11. The Impression included, but was not limited to "Fractures of the distal second, third, fourth, and fifth metatarsals." On the report faxed to the physician on 5/24/11 at 2:44 p.m., was a note faxed back from the physician "refer to ortho" and signed by the physician on 5/24/11 at 1923 (7:23) p.m.<br><br>In interview with the Director of Nursing on 6/14/11 at 2:10 p.m., she indicated she knew the consult had been completed, but documentation was lacking. No documentation<br>was found of the consult being obtained. The physician was notified on 6/16/11 at | | III. The policy for Physician Notification was reviewed and found to be appropriate by QA Committee. All nurses were reeducated on Physician Notification Policy. IV. Director of Nursing or designee will review telephone orders daily to identify outstanding specialty referrals. Director of Nursing or designee will review documentation for those residents with specialty referrals to assure proper physician notification. Director of Nursing or designee will report audit findings to QA monthly for three months and quarterly, thereafter. V. Date of Completion: July 16, 2011 | |

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| | 11:05 a.m., at which time he canceled the ortho referral.<br><br>Documentation was lacking in the clinical record of the physician being notified the referral had not been completed.<br><br>2. Review of the clinical record for Resident #51 on 6/14/2011 at 1:50 p.m., indicated the resident had diagnoses which included, but were not limited to, insulin dependent diabetes mellitus, coronary heart disease, congestive heart failure, and gastroesophageal reflux disease.<br><br>On 4/11/2011, the consultant dentist visited and made the following notations and recommendation: "Mixed red/white area 4 x [by] 5 mm [millimeter] irregular right lateral tongue. Referral to oral surgeon: right lateral tongue area - Biopsy? #30 -31 for evaluation".<br><br>Review of the nursing and social worker notes between 4/11/2011 and 6/15/2011 failed to locate documentation of the resident's primary physician and ENT specialist having been notified of the dentist's findings.<br><br>During an interview with RN #1 and LPN #1 on 6/16/2011 at 12:20 p.m., they indicated they were unaware if the | | | |

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| | primary physician and ENT specialist had been notified.<br><br>Documentation in the physician's progress notes indicated the primary physician had made a visit to see the resident for his routine check up on the evening of 4/11/2011. There was no reference to the lesion found in the resident's mouth earlier that day by the dentist.<br><br>The facility also placed calls to, or the resident saw. the ENT specialist on the following dates with no documentation of the specialist being made aware of the lesion: 4/12/2011, 5/2/2011, 5/9/2011, and May 13, 2011.<br><br>3.1-5(a)(3) | | | |
| F0253 SS=E | The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br>Based on observation, record review and interview, the facility failed to ensure furniture, over the bed lights, and ceiling fans were clean and in good repair during | F0253 | I. Ceiling fan blades of fans by nurse's station 1,2,3, and by rooms 23, 25, 29, 44, and 51 were cleaned. Room 42--The frame of 1 bed, 2 closet tops and | 07/16/2011 |

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| | environmental observations on 2 of 5 survey days. This deficient practice affected 2 of 9 rooms on Hall #1, 3 of 7 rooms on Hall #2, 4 of 13 rooms on Hall #3 and 6 of 30 rooms on Hall #4.<br><br>Findings include:<br><br>1. On 06/13/11 at 1:15 p.m., the blades of a ceiling fan above the nurses station for Hall 1, 2, and 3 were soiled with black dust.<br><br>2. At 1:30 p.m., the blades of the ceiling fans in the hallway by rooms 23, 25, 29, 44 and 51 were soiled with black dust.<br><br>On 06/16/11 between the hours of 9:28 a.m. and 10:32 a.m., the following was noted:<br><br>3. Room 42--The frame of 1 bed, 2 closet tops and 1 over bed light were soiled with heavy dust. The dust rolled up when wiped with the fingers. The cubicle curtain was soiled with small brown stains.<br><br>4. Room 49--The frame of 1 bed, 1 wood chair frame, 2 over bed lights and 2 closet tops were soiled with heavy dust. The cubicle curtain was soiled with a white and black substance and the Television | | 1 over bed light were dusted. The cubicle curtain was cleaned. Room 49--The frame of 1 bed, 1 wood chair frame, 2 over bed lights and 2 closet tops were dusted. The cubicle curtain was cleaned. Television stand was dusted. The top of the mirror in the bathroom was cleaned. Room 53--The frames of 2 beds, 2 over bed lights and 2 closet tops were dusted. Room 40--The top of 1 closet was dusted. The chair was removed. Room 31--The frame of 1 bed, 1 over bed light and 1 closet top were dusted. Room 29--The frame of 1 bed and 1 over bed light were dusted. The wall below the bathroom hand sink was cleaned. Room 24--The cover for the electric plug was repaired and cleaned. Room 11--The frame of 1 bed, and 2 closet tops were dusted. A filter was placed in the oxygen concentrator. The ceiling tile over the shower was replaced. The wood frame of a chair outside of the beauty shop was dusted. Room 124--The frames of 2 beds were dusted. Room 129--The frame of 1 bed was dusted. Room 130--The frames of 2 beds were dusted. Room 132--The frames of 2 beds and 2 over bed lights were dusted. Room 111--The frame of 1 bed and 1 closet top were dusted. Room 107--The frame of 1 bed, 1 over bed light and wood frame of 1 chair were dusted. The bumper under the hand rail outside of room 104 was | |

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| | stand was soiled with black dust. The top of the mirror in the bathroom was soiled with a white powdery substance.<br><br>5. Room 53--The frames of 2 beds, 2 over bed lights and 2 closet tops were soiled with heavy dust.<br><br>6. Room 40--The top of 1 closet was soiled with heavy dust. The wood frame of 1 chair was marred and the seat was stained.<br><br>7. Room 31--The frame of 1 bed, 1 over bed light and 1 closet top were soiled with heavy dust.<br><br>8. Room 29--The frame of 1 bed and 1 over bed light were soiled with heavy dust. Rust stains were noted on the wall below the bathroom hand sink.<br><br>9. Room 24--The cover for the electric plug was broken and only covered half of the outlet.<br><br>10. Room 11-- The frame of 1 bed, and 2 closet tops were soiled with heavy dust. The oxygen concentrator lacked a filter and the ceiling tile over the shower had dried brown stains.<br><br>11. The wood frame of a chair outside of the beauty shop was soiled with heavy | | dusted and corner piece was replaced. The bumper under the hand rail by room 132 was dusted. Corner pieces were replaced on the bumper under the hand rail between rooms 130 and 132. II. Environmental rounds were completed throughout the entire facility to identify any dusty, soiled, damaged, missing or discolored items and/or areas. III. Routine cleaning duties, schedule, sign off sheets and maintenance requisitions were drafted and approved by QA Committee. All housekeeping and maintenance staff were re-educated on proper cleaning and repairs, routine cleaning duties, schedule and sign off sheets. IV. The Administrator or designee will review sign off sheets and maintenance repair requisitions and conduct random audits of facility areas daily during walking rounds to identify any environmental needs. The results of these audits will be reviewed by QA weekly for four weeks, monthly for 2 months and then quarterly thereafter. V. Date of Completion: July 16, 2011 | |

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| | dust.<br><br>12. Room 124--The frames of 2 beds were soiled with heavy dust.<br><br>13. Room 129--The frame of 1 bed was soiled with heavy dust.<br><br>14. Room 130--The frames of 2 beds were soiled with heavy dust.<br><br>15. Room 132--The frames of 2 beds and 2 over bed lights were soiled with heavy dust.<br><br>16. Room 111--The frame of 1 bed and 1 closet top were soiled with heavy dust.<br><br>17. Room 107--The frame of 1 bed, 1 over bed light and wood frame of 1 chair were soiled with heavy dust..<br><br>18. The bumper under the hand rail outside of room 104 was soiled with dust that rolled up when swiped with the fingers. A corner piece was missing.<br><br>19. The bumper under the hand rail by room 132 was soiled with heavy dust.<br><br>20. Corner pieces were missing on the bumper under the hand rail between rooms 130 and 132. | | | |

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| | 21. In interview with the Housekeeping Supervisor at 10:15 a.m., she indicated the bed frames are washed 1 time a week on the residents shower days. She provided copies of work sheets for the halls which indicated the resident shower days.<br><br>3.1-19(f) | | | |
| F0282 SS=D | The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>A. Based on record review and interview, the facility failed to refer a resident for an ortho (orthopedic) consult for 1 of 1 resident reviewed with an ortho referral in a sample of 15. (Resident #56)<br><br>B. Based on record review and interview, the facility failed to follow their policy and procedure related to the management of constipation for 1 of 2 residents reviewed for constipation in a sample of | F0282 | I. Ortho consult for R56 was discontinued per his primary physician. R8's BM pattern is being monitored and she has had at least one BM every 3 days. II. All resident's records were reviewed for specialty consults with no outstanding referrals noted. All resident's BM records were reviewed. Those residents who had not had a BM within the last 3 days received laxative according to facility policy with results. III. The policy for | 07/16/2011 |

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| | 15. (Resident #8)<br><br>Findings include:<br><br>A. The clinical record for Resident #56 was reviewed on 6/14/11 at 1:25 p.m. The resident's diagnoses included, but were not limited to below knee amputation and fracture distal second, third, fourth, and fifth metatarsals of uncertain age. The resident had an X-ray of the right foot completed on 5/24/11. The Impression included, but was not limited to "Fractures of the distal second, third, fourth, and fifth metatarsals." On the report faxed to the physician on 5/24/11 at 2:44 p.m., was a note faxed back from the physician "refer to ortho" and signed by the physician on 5/24/11 at 1923 (7:23) p.m.<br><br>In interview with the Director of Nursing on 6/14/11 at 2:10 p.m., she indicated she knew he had the consult and remembered the conversation. No documentation was found of the consult being obtained. Documentation was lacking of the referral being made. On 6/16/11 at 2:40 p.m., the Administrator provided a Telephone Order to "cancel the ortho referral."<br>B. On 6/13/2011 at 1615 (415) p.m. the clinical record for Resident #8 was reviewed. The resident's diagnoses | | Physician Notification and BM Protocol were reviewed and found to be appropriate by QA Committee. A policy for Physician Referrals was drafted and found to be appropriate by QA Committee. All nurses will be educated on Physician Referrals Policy, Physician Notification Policy and BM protocol. IV. Director of Nursing or designee will review telephone orders daily to identify outstanding specialty referrals. Director of Nursing or designee will review documentation for those residents with specialty referrals to assure proper physician notification and follow up. Director of Nursing or designee will review BM monitoring records daily to identify any resident who has not had a BM in last three days. Identified residents will be placed on a log. Nurses will be instructed to follow BM protocol. Director of Nursing or designee will review log daily to assure proper following of BM protocol. Director of Nursing or designee will report audit findings to QA monthly for three months and quarterly, thereafter.V. Date of Completion: July 16, 2011 | |

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| | included , but were not limited to; Alzheimer's disease, hypertension, dementia, cerebral vascular accident (stroke), and constipation.<br><br>On 6/13/2011 at 1615 p.m. [4:15 p.m.] the BM monitoring sheet for May 2011 was reviewed. Resident # 8 had not had a bowel movement from the night of 5/8/2011 to the night of 5/14/2011, 6 days total and did not have another until 5/23/2011, 8.5 days total.<br><br>On 6/13/2011 at 1615 p.m. [4:15 p.m.] the May 2011 Medication Record indicated Milk of Magnesia Suspension take 30 cc (cubic centimeters) by mouth once daily as needed for constipation was ordered on 09/19/08 and discontinued on 3/25/11. MOM (milk of magnesia) Give 30 cc po (by mouth) daily PRN (as needed) constipation R/T (related to) narcotic ordered 4/6/11 was discontinued.<br><br>On 6/15/2011 at 09:45 a.m. review of the facilities Management of Constipation undated policy indicated, but was not limited to; "it is the policy of this facility to assist residents to maintain normal bowel movements, at least 3 times per week with staining less than 25% of the time." The facility defines constipation as having 2 or fewer bowel movements per week. The Procedure indicates "it shall be | | | |

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| | the responsibility of the charge nurse for each unit to monitor the documentation of bowel movements every shift", "the Day Shift Charge Nurse for each unit will complete the laxative list for any resident who has not had a BM in 3 days", "The Evening Shift Nurse will offer the PRN laxative to any resident who is on the laxative list", if the resident has not had a BM within 24 hours after receiving the PRN (or refusal of the laxative), a Fleets Enema may be offered/given if ordered by the physician; if not ordered, then the physician should be contacted for further orders", "if the resident has not had a BM following the above interventions, the physicians should be contacted".<br><br>On 6/13/2011 at 09:45 a.m., the Assistant Director of Nursing (ADON) indicated that they follow their policy and procedure relating to constipation.<br><br>3.1-35(g)(2) | | | |
| F0309 SS=D | Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br>Based on record review and interview, | F0309 | I. R8's BM pattern is being | 07/16/2011 |

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| | the facility failed to monitor the residents bowel movements, provide medication and notify the physician related to the management of constipation for 1 of 2 residents reviewed for constipation in a sample of 15. (Resident #8)<br><br>Findings include:<br><br>On 6/13/2011 at 1615 [4:15 p.m.] the clinical record for Resident #8 was review ed. The resident's diagnoses included , but were not limited to; Alzheimer's, hypertension, dementia, cerebral vascular accident (stroke), and constipation.<br><br>On 6/13/2011 at 1615 p.m. the BM monitoring sheet for May 2011 was reviewed. Resident # 8 had not had a bowel movement from the night of 5/8/2011 to the night of 5/14/2011, 6 days total and did not have another until 5/23/2011, 8.5 days total.<br><br>On 6/13/2011 at 1615 p.m., [4:15 p.m.] the May 2011 Medication Record indicated Milk of Magnesia Suspension take 30 cc (cubic centimeters) by mouth once daily as needed for constipation was ordered on 09/19/08 and discontinued on 3/25/11. MOM (milk of magnesia) Give 30 cc po (by mouth) daily PRN (as needed) constipation R/T (related to) | | monitored and she has had at least one BM every 3 days. II. All resident's BM records were reviewed. Those residents who had not had a BM within the last 3 days received laxative according to facility policy with results. III. The BM Protocol was reviewed and found to be appropriate by QA Committee. All nurses will be educated on BM protocol. IV. Director of Nursing or designee will review BM monitoring records daily to identify any resident who has not had a BM in last three days. Identified residents will be placed on a log. Nurses will be instructed to follow BM protocol. Director of Nursing or designee will review log daily to assure proper following of BM protocol. Director of Nursing or designee will report to QA Monthly for three months and quarterly, thereafter. V. Date of Completion: July 16, 2011 | |

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| | narcotic ordered 4/6/11 was discontinued.<br><br>On 6/15/2011 at 09:45 a.m. review of the facilities Management of Constipation undated policy indicated, but was not limited to; "it is the policy of this facility to assist residents to maintain normal bowel movements, at least 3 times per week with staining less than 25% of the time." The facility defines constipation as having 2 or fewer bowel movements per week. The Procedure indicates "it shall be the responsibility of the charge nurse for each unit to monitor the documentation of bowel movements every shift", "the Day Shift Charge Nurse for each unit will complete the laxative list for any resident who has not had a BM in 3 days", "The Evening Shift Nurse will offer the PRN laxative to any resident who is on the laxative list", if the resident has not had a BM within 24 hours after receiving the PRN (or refusal of the laxative), a Fleets Enema may be offered/given if ordered by the physician; if not ordered, then the physician should be contacted for further orders", "if the resident has not had a BM following the above interventions, the physicians should be contacted".<br><br>On 6/13/2011 at 09:45 a.m. Assistant Director of Nursing (ADON) indicated they follow their policy and procedure relating to constipation. | | | |

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| | 3.1-37(a) | | | |
| F0312 SS=D | A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>Based on observation, interview, and record review, the facility failed to provide personal hygiene as outlined in the facility policy to a dependent resident for 2 of 5 incontinent residents observed in a sample of 15 and 1 of 1 resident observed for incontinence care in a supplemental sample of 7. (Residents' # 8, 24, 37)<br><br>Findings include:<br><br>1. On 06/13/11 at 1:44 p.m., Certified Nursing Assistants #'s 1 and #2, were observed to provide incontinent care to Resident # 24. The resident was transferred from the chair to the bed and her brief was removed. A large amount of pasty stool was noted in the brief. The stool was on her buttocks and in the vaginal area. CNA #1, indicated he had last changed the resident two hours prior. CNA #1 wiped the front of the resident and wiped between her legs using three | F0312 | I. R24, R8 and R37 were assessed by licensed nurse and found to be clean and free from adverse outcomes related to identified practices. II. All residents who are dependent upon staff to provide perineal care were identified through review of MDS data. All identified residents were assessed and found to be clean and free from signs/symptoms of adverse outcomes related to perineal care. III. The facility's policy for Perineal Care was reviewed and found appropriate by QA Committee. Senior C.N.A. Mentor will be reeducated on Perineal Care by Director of Nursing or designee and return demonstration will be conducted to assure competency. All C.N.A.' s will be reeducated on perineal care and return demonstrations will be conducted by Senior C.N.A. Mentor. IV. The Director of Nursing or designee will conduct random audits of perineal care 2 x's weekly for 2 weeks, weekly for 2 weeks, and monthly for 2 | 07/16/2011 |

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| | wash cloths. The CNA looked in the closet and 1 drawer for clean briefs using the same gloves used to clean stool from the resident. A clean brief and pants were applied using the soiled gloves used to clean stool. The CNA failed to separate the labia, or cleanse the vaginal area.<br><br>2. On 6/15/11 at 8:52 a.m., Resident #8, was observed up in a reclining geri chair in the dining room for the 100, 200, and 300 halls. At 9:52 a.m. Certified Nursing Assistant (CNA) #3, was observed to take the resident to her room.<br><br>The CNA #3 when queried at that time, indicated that the night shift had gotten the resident out of bed before ending their shift at 6:00 a.m. She further indicated she had not changed the resident since she came on duty at 6:00 a.m.<br><br>At 9:52 a.m., CNA #3 placed a gait belt around the resident's waist and transferred her from the chair to the bed.<br>At 9:59 a.m., CNA #3 left the room to obtain wash cloths. Upon return she donned gloves and removed peri wash from a dresser drawer and sprayed the peri wash on one cloth. She removed the residents sweat pants and brief. The brief was soiled with urine. CNA #3 wiped the pubic area with the cloth, turned the resident toward the window and using a | | months. The results of these audits will be reported to QA Committee monthly for three months and quarterly, thereafter.V. Date of Completion: July 16, 2011 | |

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| | dry cloth cleansed a small smear of stool from the anal area. Without washing her hands or removing her gloves she again opened the dresser drawer. She indicated she was looking for cream to apply to the resident's buttocks.<br><br>At 10:03 a.m., CNA #3 removed her gloves and without handwashing left the room to obtain cream from the supply closet. Upon return, she donned gloves without handwashing and put the "skin protectant cream" on the resident's buttocks. CNA #3 applied a clean brief, adjusted the oxygen canula, sheet and bedspread without removing the soiled gloves or washing her hands.<br><br>At 10:08 a.m., the CNA #3, removed her gloves and washed her hands. She failed to wash between the resident's legs, or spread the labia to wash the urine from the resident's skin.<br><br>On 06/16/11 at 2:41 p.m., the Assistant Director of Nursing provided the facility's Procedure for Perineal Care. She indicated the procedure was the same as the Indiana State Department of Health Standards.<br><br>The procedure indicated the following:<br><br>Bullet 3. Assist resident to supine | | | |

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| | position.<br>Bullet 4. Place waterproof pad under the resident's hips.<br>Billet 5. Drape resident.<br>Bullet 6. Fill wash basin with warm water and have resident check water temperature.<br>Bullet 7. Put on gloves.<br>Bullet 8. Assist resident to spread legs and lift knees if possible.<br>Bullet 9. Wet and soap folded washcloth<br>Bullet 11. Wipe from front to back and from center of perineum to thighs. Change washcloth as necessary for females.<br>A. Separate labia. Wash urethral area first<br>B. Wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use a different part of washcloth for each stroke.<br><br>On 06/17/11 at 10:25 a.m., the Senior CNA Mentor provided copies of the skills check list for the CNA #'s 1, 2, 3, and 4. She indicated the above CNA's skills were checked upon hire and again on 04/14/11. She indicated the repeat skills check was completed to ensure all CNAs were competent in care needs.<br><br>On 06/17/11 at 10:45 a.m., the skills checklist for the Senior CNA Mentor | | | |

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| | which was completed on 04/13/11 was reviewed.<br><br>All CNAs including the mentor were checked off as competent in incontinence care.<br>3. During observation on 6/16/2011 at 08:50 a.m.,. Certified Nursing Aide (CNA) # 4 performed peri care on Resident # 37. CNA # 4 entered the resident's room and asked Resident # 37 if it was ok if she did her peri care. CNA # 4 applied a gait belt to resident # 37 and walked her to the bathroom. CNA # 4 washed hands and applied gloves and then sat resident # 37 on the toilet. CNA #4 prepared plastic bags and wet 2 washcloths applying soap to 1 washcloth. The CNA asked the resident to stand up holding on to the bar. The CNA stood behind the resident and used the cloth with soap wiping front to back swiping 2 times, and then used the rinse cloth swiping one time. The CNA patted the area dry with a towel and pulled the brief up. CNA #4 removed the gloves and washed hands and walked resident back to bed.<br><br>3.1-38(a)(3)(A) | | | |

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| F0323 SS=E | The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview and record review, the facility failed to ensure hazardous materials were secured properly on 1 of 5 survey days. This deficient practice had the potential to affect 5 residents identified with dementia in a census of 15 residents on Hall 1. [Residents' # 1, 2, 4, 11, & 12]<br><br>Findings include:<br><br>1. On 06/13/11 at 1:25 p.m., the door to the Certified Nursing Supply closet on the 100 Hall was unlocked and unattended.<br><br>The following items were in the closet:<br><br>1. Evoke Total Bodywash and Shampoo 11 bottles.<br>The Material Safety Data Sheet provided by the Assistant Director of Nursing (ADON) at 3:45 p.m. indicated the following under First Aid Measures:<br><br>Eye contact: Do not rub eyes. Flush eyes thoroughly with water for 15 minutes. If condition worsens or irritation persists, contact physician.<br><br>Ingestion: Do not induce vomiting. | F0323 | I. Certified Nursing supply closet on Hall 100 was locked. II. Rounds were completed throughout the facility to assure all storage areas were locked. III. All staff will be reeducated on the facility's expectation that storage areas are locked at all times. IV. The administrator or designee will check all storage areas daily during walking rounds to assure they are locked. The administrator or designee will report results of audits to QA monthly for 3 months and quarterly thereafter. V. Date of Completion: July 16, 2011 | 07/16/2011 |

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| | Contact a physician or Poison Control Center.<br><br>2. Nightingale Perineal Wash 1 bottle.<br><br>The Material Safety Data Sheet, provided by the ADON, indicated the following under First Aid Measures:<br><br>Eye Contact: Do not rub eyes. Flush eyes thoroughly with water for 15 minutes. If condition worsens or irritation persists, contact physician.<br><br>Ingestion: Do not induce vomiting. Contact a physician or Poison Control Center.<br><br>3. EVOKE Total Body Moisturizing Lotion 6 bottles.<br>The Material Safety Data Sheet provided by the ADON indicated the following under the First Aid Measures.<br><br>Eye contact: Do not rub eyes. Flush eyes thoroughly with water for 15 minutes. If condition worsens or irritation persists, contact physician.<br><br>Ingestion: Do not induce vomiting. Contact a physician or Poison Control Center.<br><br>4. Zinc Oxide Ointment 20 packets. | | | |

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| | The Material Safety Data Sheet provided by the ADON indicated the following under the First Aid Measure Section.<br><br>Eyes: Flush eyes with plenty of water for at least 15 minutes.<br><br>Ingestion: If swallowed, get medical help or contact a Poison Control Center right away. Never give anything by mouth to an unconscious person.<br><br>5. Razors 29.<br><br>On 6/13/11 in interview with the unit manager at 1:25 p.m., she indicated the room was supposed to be kept locked when staff were not in attendance. 5 resident's on the unit were identified with dementia in a census of 15 residents on Hall 1. [Residents' # 1, 2, 4, 11, & 12]<br><br>3.1-45(a)(1) | | | |

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| F0328 SS=D | The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>Based on record review, interview and observation, the facility failed to follow their policy and procedure related to flushing of peripheral inserted central catheter (PICC) lines and maintaining standard precautions for 1 of 1 resident reviewed with a PICC line in a sample of 15. (Resident #56)<br><br>Findings include:<br><br>On 6/14/2011 at 1430 [2:30 p.m.] the clinical record for Resident # 56 was reviewed. The resident's diagnoses included, but were not limited to: left below knee amputation, methicillin resistant staphylococcal aureus (MRSA) related to left stump and receiving intravenous antibiotic therapy through a peripheral inserted central catheter.<br><br>On 6/14/2011 at 1300 [1:00 p.m.] upon observation LPN #1 entered resident #56's room applied gloves and mixed the antibiotic medication then spiked the bag | F0328 | I. Resident #56 was assessed and found to have no signs/symptoms of adverse outcomes related to identified practice. II. All residents were reviewed for the presence of PICC lines. No other resident was identified. III. LPN #1 was suspended from further resident contact and was not permitted to return to resident care until return demonstration of medication administration via PICC line was completed correctly. The facility's policy for Medication Administration via PICC line was reviewed and found to be appropriate by QA Committee. All nurses will be educated on medication administration via PICC line. IV. The Director of Nursing or designee will conduct random audits of medication administration via PICC line weekly for four weeks and then monthly for 2 months. The results of these audits will be reported to QA Committee monthly for 3 months and quarterly, thereafter.V. Date of Completion: July 16, 2011 | 07/16/2011 |

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| | and primed the tubing. In the process of spiking the medication she dropped the end of the tubing, which did not have an end cap on it, on the floor. She immediately picked it up and placed the tubing in the Plum pump (automatic medication dispenser) and then connected the end of the tubing to the PICC line. LPN #1 did not use alcohol swabs or wash hands at anytime during the process and used the tubing that had fallen on floor.<br><br>On 6/14/11 at 2:45 pm., the DoN provided the facilities Policy and Procedure for the flushing of PICC lines which indicated, but was not limited to; "wash hands, thoroughly clean injection ports with alcohol swab, attach saline syringe and flush, clean injection port again with alcohol swab, aseptically attach infusion tubing or syringe with medication to the injection port and begin administration of infusion<br><br>On 6/17/2011 at 09:50 a.m. in an interview with the Administrator she indicated that LPN # 1 had been trained in the care of PICC lines and infection control.<br><br>On 6/17/2011 at 09:50 a.m. record review of the clinical skills validation checklist for LPN # 1 indicated the PICC care and | | | |

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| | infection control was completed on 4/12/2011.<br><br>3.1-47(a)(2) | | | |
| F0371 SS=F | The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br>Based on observation and interview, the facility failed to ensure staff washed their hands, equipment was clean, food temperatures were recorded, and food was dated and discarded after three days for 1 of 2 dietary observations. This deficient practice had the potential to affect 66 of 66 health center residents.<br><br>Findings include:<br><br>On 06/13/11 between the hours of 11:49 a.m. 12:25 p.m. the following was observed:<br><br>1. The 3 door refrigerator was soiled with a sticky orange substance on the floor of the refrigerator.<br><br>2. A. Seven peanut butter and jelly sandwiches on a plate lacked a date. The Dietary Manager indicated everything | F0371 | I. The 3 door refrigerator was cleaned. All undated food items were discarded. The food slicer was cleaned. Food temperatures are being recorded prior to each meal service. The microwave oven was cleaned. The floor mats were removed and are no longer stored with food items. The gasket on the chest freezer was repaired. Plastic tubs and utensils were cleaned. The container lids were cleaned. Covers were placed over the lights above the storage area for steam table pans and back door exit. Bowls and cups were cleaned. II. Daily Sanitation Checks were completed to identify any further kitchen sanitation issues. None were identified. III. Dietary Aide #1 was reeducated on proper food handling and hand washing. Dietary cleaning schedules and Daily Rounds form were drafted and approved by QA Committee. All dietary employees will be | 07/16/2011 |

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| | should be dated and be discarded after three days.<br>B. Two plates with tomato slices without a date.<br>C. Two lettuce salads without a date.<br>D. A container of fruit cocktail without a date.<br>E. A large container of fruit cocktail dated 5/25/11.<br>F. Seven dishes of cottage cheese without a date.<br>G. Eighteen small dishes of applesauce without a date.<br>I. A container of Mandarin oranges lacked a date.<br><br>3. The food slicer was soiled with dried food debris. The Dietary Manager indicated it was last used the evening before.<br><br>4. Food temperatures for the breakfast meal were not recorded at 11:50 a.m. In interview with the cook, at this time, she indicated she took them but failed to record them.<br><br>5. The microwave oven was soiled on the inner surface with a sticky brown substance.<br><br>6. Two rubber floor mats were rolled up on a shelf under the prep counter. The Dietary Manager indicated the mats were | | reeducated on proper food storage and labeling, proper cleaning techniques, proper food handling, hand washing and meal time temperature recording. IV. The Dietary Supervisor or designee will conduct daily audits of food storage, food labeling, food temperature logs and sanitation of dietary department. The results of these audits will be reported to QA weekly for four weeks, monthly for two months and quarterly thereafter. V. Date of Completion: July 16, 2011 | |

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| | placed on the shelf when the floor was mopped last evening. Packages of Kool Aid and plastic bags were also stored on the shelf.<br><br>7. The gasket on the chest freezer was loose approximately 12 inches in one area and 2 inches in a second area.<br><br>8. Plastic tubs with utensils stored in them were soiled with food crumbs/debris on the inner surfaces.<br><br>9. The lids of the containers for sugar and food thickener were soiled with a sticky substance.<br><br>10. Dietary aide #1, was observed to drop margarine pats on the floor and lifted the lid of the trash can with bare hand and disposed of the margarine. She continued to prepare the trays for lunch without washing her hands.<br><br>11. The ceiling lights in the storage area for steam table pans and the back door exit lacked a cover.<br><br>12. Eleven of sixteen bowls stored as clean were soiled with food debris on the inner surfaces.<br><br>13. Eight of sixteen cups stored as clean were soiled with food debris on the inner | | | |

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| | surfaces.<br><br>3.1-21(a)(2)<br>3.1-21 (i)(3) | | | |
| F0411<br>SS=D | The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.<br>Based on record review and interview, the facility failed to follow up in a timely manner on a dentist's referral for 1 of 15 residents reviewed for dental services to see an oral surgeon in a sample of 15 residents. (Resident #51) | F0411 | I. R51 is schedule to see oral surgeon on July 7, 2011II. All residents with dental referrals are at risk to be affected. All resident records were reviewed and no outstanding referrals were noted. III. A policy for Physician Referrals was drafted and found | 07/16/2011 |

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| | Finding includes:<br><br>Review of the clinical record for Resident #51 on 6/14/2011 at 1:50 p.m., indicated the resident had diagnoses which included, but were not limited to, insulin dependent diabetes mellitus, coronary heart disease, congestive heart failure, and gastroesophageal reflux disease.<br><br>On 4/11/2011, the consultant dentist visited and made the following notations and recommendation: "Mixed red/white area 4 x [by] 5 mm [millimeter] irregular right lateral tongue. Referral to oral surgeon: right lateral tongue area - Biopsy? #30 -31 for evaluation".<br><br>A note was made at the bottom of this form by the social worker "Call placed to [name of oral surgeon]. He will be in to see res [resident] on May 3rd between 2-3." Documentation was lacking of the oral surgeon having made the visit on May 3.<br><br>During an interview with the social worker on 6/16/2011 at 11:00 a.m., she indicated the oral surgeon had come in on that day - May 3 - but because the resident was eating lunch at the time, he did not want to bother him and indicated he would be back as he had other patients to | | to be appropriate by QA Committee. All nurses will be educated on Physician Referrals Policy. IV. Director of Nursing or designee will review telephone orders daily to identify outstanding specialty referrals. Director of Nursing or designee will review documentation for those residents with specialty referrals to assure proper scheduling and follow up. Director of Nursing or designee will report audit findings to QA monthly for three months and quarterly, thereafter. V. Date of Completion: July 16, 2011 | |

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| | see. The social worker indicated she had not followed up to make another appointment until it was brought to her attention that day - 6 weeks after the initial visit.<br><br>3.1-24(a)(1)<br>3.1-24(a)(3)<br>3.1-24(b) | | | |

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| F0441 SS=D | The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | | | |
| | A. Based on record review and interview, the facility failed to ensure newly admitted residents received a tuberculin skin test upon admission for 2 of 3 newly admitted residents reviewed in a sample | F0441 | I. Resident 20 and 11 have received initial PPD and will receive 2nd step according to facility policy. Resident #56 was assessed and found to have no signs/symptoms of adverse | 07/16/2011 |

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| | of 15. (Residents' #11, 20)<br><br>B. Based on record review, interview and observation, the facility failed to ensure Standard and Contact Precautions were followed according to facility policy and procedure for 1 of 2 residents reviewed with a dressing change in a sample of 15. (Resident #56)<br><br>Findings include:<br><br>A. 1. The clinical record for Resident #11 was reviewed on 6/14/11 at 12:25 p.m. The resident's diagnoses included, but were not limited to Parkinson's disease and immobility syndrome. The resident was admitted to the facility on 6/9/11. The first step PPD (purified protein derivative) was administered on 6/11/11 as documented on the June 2011 Medication Administration Record.<br><br>A. 2. The clinical record for Resident #20 was reviewed on 6/14/11 at 9 a.m. The resident's diagnoses included, but were not limited to dementia and diabetes mellitus. The resident was admitted to the facility on 6/7/11. The first step PPD was administered on 6/13/11.<br><br>On 6/15/11 at 2:25 p.m., in interview with the Director of Nursing, she indicated the PPD was due within 24 hours of | | outcomes related to identified practice. II. All resident records were reviewed for the presence of documented 2 step PPD upon admission. Those residents without documentation of 2 step PPD will have initial PPD administered and then 2nd step according to facility policy. All residents were reviewed for the presence of PICC lines. No other resident was identified. All residents with wounds were identified. All wounds were assessed by licensed nurse and none found to show signs/symptoms of adverse outcomes related to dressing changes. III. The facility's policy on PPD administration upon admission was reviewed and found to be appropriate by QA Committee. All nurses will be reeducated on PPD administration requirements upon admission. A Nurse's Admission Checklist and an IDT Admission Checklist were developed that include admission PPD. LPN #1 was suspended from further resident contact and was not permitted to return to resident care until return demonstration of medication administration via PICC line and clean dressing change was completed correctly. The facility's policies for Medication Administration via PICC line and clean dressing change were reviewed and found to be appropriate by QA Committee. All nurses will be | |

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| | admission.<br><br>B. 1. On 6/14/2011 at 2:30 p.m. the clinical record of Resident # 56 was reviewed. The resident's diagnoses included, but were not limited to; left below knee amputation, methicillin resistant staphylococcal aureus (MRSA) related to left stump and receiving intravenous antibiotic therapy through a peripheral inserted central catheter.<br><br>During observation on 6/14/2011 at 1:00 p.m. the Licensed Practical Nurse (LPN) # 1 failed to maintain Standard Precautions while flushing the Peripheral Inserted Central Catheter (PICC) and | | reeducated on medication administration via PICC line and clean dressing change. IV. The admitting nurse, 1st nurse to follow admit and 2nd nurse to follow admit will review and sign off on Admission Checklist. Director of Nursing or designee will review Nurses Admission Checklist, new admit clinical records and record findings on IDT Admission checklist within 24 hours of admission. The Director of Nursing or designee will conduct random audits of medication administration via PICC line and clean dressing changes weekly for four weeks and then monthly for 2 months. The results of these audits will be reported to QA Committee monthly for 3 months. V. Date of Completion: July 16, 2011 | |

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| | administering intravenous antibiotic. LPN #1 failed to follow facility policy and procedure for the flushing of PICC lines which indicated, but was not limited to; "wash hands, thoroughly clean injection ports with alcohol swab, attach saline syringe and flush, clean injection port again with alcohol swab, aseptically attach infusion tubing or syringe with medication to the injection port and begin administration of infusion". LPN #1 entered the room applied gloves and mixed the antibiotic medication then spiked bag and primed tubing. In the process of spiking the medication she dropped the end of the tubing, which did not had a end cap on it, on the floor. She immediately picked it up and placed tubing in Plum pump (automatic medication dispenser) and then connected end of the tubing to the PICC line. LPN #1 did not use alcohol swabs or wash hands at anytime during the process and used the tubing that had fallen on floor. LPN # 1 then proceeded with the dressing change as described below without removing gloves.<br><br>On 6/14/2011 at 1:50 p.m. Licensed Practical Nurse (LPN) # 1 was observed with gloves on from the administration of medication previously noted, LPN # 1 removed the boot posey from the right foot, she then removed three old dressings | | | |

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| | on right shin, toe and heel with scissors taken from her pocket. She washed right shin, right second toe and right heel with normal saline and applied a 6 x 3 pad to shin and 2 x 2 gauze to second toe, she then used the same scissors, which she used to remove the dirty dressing, to cut a piece of mepilex (spongy dressing) and applied to right heel. LPN # 1 removed gloves and applied new gloves and then wrapped two Kerlix (long gauze dressing) around right heel up to shin. LPN # 1 removed dressing from the left stump and then removed gloves and put on new gloves. Two spots noted on stump, # 1 area 0.5 x 0.25 on inner right of stump and # 2 area 1 x 1 on right inner thigh just above knee. LPN # 1 placed hydrogel on a 3 x 4 telfa (non stick dressing) and applied to area # 1 and with same scissors cut a piece of mepilex and applied to area # 2. Resident # 56 had a box of elastic dressings in room that LPN # 1 cut a length off and dropped on floor, she picked it up and proceeded to apply over dressing on left stump. LPN # 1 tied up garbage bag with dirty dressings in it and picked up left over supplies on bed and walked out of room. LPN # 1 placed left over supplies on treatment cart, placed scissors back in pocket and took garbage bag to dirty utility room.<br><br>The Multi Drug Resistant Organisms | | | |

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| | Policy provided by RN #1 on 6/14/11 at 2:45 p.m., included, but was not limited to: "Staff will use standard precautions as the primary approach to preventing transmissions of MDROs [multi drug resistant organisms], Caregivers should wash their hands with soap and water after physical contact with infected or colonized person and before leaving the facility, Make antiseptic handwashing agent and/or approved alcohol-based hand disinfectant available, hands should be washed after removing the gloves".<br><br>On 6/17/2011 at 09:50 a.m., in an interview with the Administrator she indicated that LPN # 1 had been trained in the care of PICC lines and infection control. Administrator indicated that she had been trained separately on the clinical skills validation because she was out the day of training which was on 3/29/2011.<br><br>On 6/17/2011 at 09:50 a.m. record review of the clinical skills validation checklist for LPN # 1 indicates that PICC care and infection control was completed on 4/12/2011.<br><br>3.1-18(e) | | | |

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| F0465 SS=D | The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview, the facility failed to ensure the downspout was in good repair and the drain was clear, during a torrential rain fall during 1 of 5 days. (June 15, 2011) (Resident #100 and 101)<br><br>Findings include:<br><br>On 6/15/11 the following was observed:<br><br>At 8:32 a.m., resident's #100 and 101 were observed seated in the smoking area during a rain. During interview at that time, resident #101 indicated to be careful as rain was dripping from a wire above the door. He indicated some stones had to be placed in a hole near the air conditioner to the dining area, as water would flow off the gutter and the hole continued to expand.<br><br>At 10 a.m., resident #101 brought an umbrella to the surveyors so as to check out the gutter near the smoke area. At this time, the rain was coming down extremely hard. On nearing the door, the water could be observed pouring like a waterfall from the elbow on the gutter. It was pouring so hard and fast that the drain | F0465 | I. Identified gutter was repaired. II. All guttering was inspected and found to be in working order. III. Gutter inspection was added to weekly Maintenance Audit. IV. Maintenance Director or designee will inspect guttering weekly to assure proper working order. Results of audits will be reported to QA monthly for 3 months. V. Date of Completion: July 16, 2011 | 07/16/2011 |

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| | in the sidewalk would not drain and water began to accumulate over the sidewalk near where 2 residents were seated. In interview with the Maintenance Director, at this time, he indicated the gutter needed an elbow as water was overshooting the roof and the drain was not working.<br><br>3.1-19(f) | | | |
| F0514<br>SS=D | The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br>Based on record review and interview, the facility failed to ensure physician progress notes were on the clinical record for 1 of 15 sampled residents progress notes reviewed. (Resident #20)<br><br>Findings include:<br><br>The clinical record for Resident #18 was reviewed on 6/13/11 at 2:25 p.m. The resident's diagnoses included, but were not limited to; congestive heart failure and | F0514 | I. Resident 18's progress notes were placed in medical record II. All resident's medical records were reviewed for missing progress notes. No missing notes were noted. III. A Physician's Visit Follow Up log was drafted. All nurses were reeducated on the necessity of progress notes to be placed in the residents' medical records following a physician visit. IV. The Director of Nursing or designee will review the Physician's Visit Follow Up log daily to assure proper receipt and | 07/16/2011 |

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| | 155616 | A. BUILDING 00<br>B. WING | 06/17/2011 |

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| | chronic obstructive heart disease. The resident was readmitted to the facility on 1/14/11.<br><br>When reviewing for Physician Progress Notes, documentation was lacking in the record. In interview with RN #1, on 6/14/11 at 8:35 a.m., she indicated there were no Progress Notes in the record as the resident goes to the physician's office. At 10:05 a.m., she indicated she had sent someone to the physician's office to get copies of the visits as the fax machine did not work. On 6/14/11 at 11:55 a.m., the Progress Notes were placed in the clinical record, but failed to have the dates readable.<br><br>On 6/17/11 at 10:17 a.m., the Director of Nursing provided the completed dates for the notes placed in the record 1/15/09, 2/19/09, 3/24/09, 7/19/10 , 7/28/10, and 1/27/11.<br><br>3.1-50(a)(1)<br>3.1-50(a)(2) | | filing of progress notes. The results of this audit will be reported to QA monthly for 3 months and quarterly, thereafter. V. Date of Completion: July 16, 2011 | |
| R0000 | The following State Residential Findings are cited in accordance with 410 IAC 16.2-5. | R0000 | **This plan of correction is to serve as Landmark Nursing & Rehabilitation Center's credible** | |

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| | | | **allegation of compliance. Submission of this plan of correction does not constitute an admission by Landmark Nursing & Rehabilitation Center or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** | |
| R0144 | (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.<br>Sanitation and Safety Standards: 5.1-5(a)<br><br>Based on observation and interview, the facility failed to ensure 10 of 10 residential dining room chairs were in good repair.<br><br>Finding includes:<br><br>On 6/14/11 at 2 p.m., 6/16/11 at 11 a.m., and 6/17/11 at 8:30 a.m., 10 of 10 wooden frame chairs with cloth seat and backs were observed in the dining room of the residential area. All 10 chairs were marred with multiple nicks on the legs, the seats had beige stains in the cloth with 1(one) chair having a dime size hole in the seat and the varnish on the arms was worn on all 10 chairs.<br><br>During an interview with the housekeeping supervisor on 6/17/2011 at 11:15 a.m., she indicated there was no routine cleaning schedule for the chairs in the dining room - they were spot | R0144 | I. 10 of 10 chairs have been repaired in Residential Area.II. Review of other chairs in dining room completed with no other concerns identified. III. Housekeeping and Residential Staff were re-educated to validate chairs were in good repair, weekly. Any identified concern will be submitted on a Building Services Request Form. IV. The Housekeeping Supervisor or designee will conduct audits. twice/weekly of Residential Dining Area to ensure chairs are in good repair. The results of these audits will be reported to QA weekly for four weeks, monthly for two months and quarterly thereafter. V. Date of Completion: July 16, 2011 | 07/16/2011 |

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| | checked and cleaned. | | | |
| R0214 | (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.<br>Based on record review and interview the facility failed to ensure the service plan and evaluation was reviewed/revised semiannually for 1 of 2 closed records reviewed in a sample of 7 (Residential Resident #7)<br><br>Findings include:<br><br>The clinical record for residential resident #7 was reviewed on 6/14/11 at 2:15 p.m. The resident's diagnoses included, but were not limited to history of kidney stones, depression and pain. The resident was admitted to the facility on 5/28/10 and discharged on 3/31/11. Documentation was lacking of a semi-annual evaluation completed in November 2010.<br><br>On 6/15/11 at 11 a.m., with the Medical Records Designee, she indicated she was going to look through the resident record for the Service Plan and a completed | R0214 | I. Resident #7 no longer resides in facility.<br>II. All current Resident Service Plan and Assessments were reviewed/revised.<br>III. Residential Care Staff were educated to completea a Resident Service Plan and Assessments upon admission and every six months thereafter or when a change in condition occurs.<br>IV. The Director of Nursing or designee will conduct audits of the medical records to ensure the Resident Service Plan and Assessments are completed upon admission, and every six months thereafter or when a change in condition occurs.The results of these audits will be reported to QA weekly for four weeks, monthly for two months and quarterly thereafter.<br>V. Date of Completion: July 16, 2011 | 07/16/2011 |

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| | evaluation. She returned and indicated the documentation was not located. | | | |
| R0217 | (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:<br>(1) The services offered to the individual resident shall be appropriate to the:<br>(A) scope;<br>(B) frequency;<br>(C) need; and<br>(D) preference;<br>of the resident.<br>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.<br>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.<br>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.<br>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.<br>Based on record review and interview the facility failed to ensure the Service Plan and an Evaluation was completed on admission for 1 or 7 sampled residents reviewed for an evaluation and service | R0217 | I. Resident #6 no longer resides in Residential Area.II. All current Resident Service Plan and Assessments were reviewed/revised.III. Residential Care Staff were educated to completea a Resident Service | 07/16/2011 |

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| | plan. (Residential Resident #6)<br><br>Findings include:<br><br>The clinical record for Resident #6 was reviewed on 6/14/11 at 2:20 p.m. The resident's diagnoses included, but were not limited to chronic obstructive pulmonary disease and disorder of the prostate.<br>The resident was admitted on 2/13/11 and discharged to hospital on 5/10/11.<br><br>On 6/15/11 at 11 a.m., the Medical Record Designee was going to look through the resident record for the Service Plan and a completed evaluation. At 11:15 in interview with RN #1, she indicated all of the regular assessments were done, but not the Service Plan. | | Plan and Assessments upon admission and every six months thereafter or when a change in condition occurs.IV. The Director of Nursing or designee will conduct audits of the medical records to ensure the Resident Service Plan<br>and Assessments are completed upon admission, and every six months thereafter or when a change in condition occurs.The results of these audits will be reported to QA weekly for four weeks, monthly for two months and quarterly thereafter. V. Date of Completion: July 16, 2011 | |
| R0273 | (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.<br>Food and Nutritional Services: 5.5-1(f)<br><br>Based on observation and interview the facility failed to ensure hands were washed, equipment was clean, food temperatures were recorded, food was dated and discarded after three days for 1 of 2 dietary observations. This deficient practice had the potential to affect 15 residential residents. | R0273 | I. The 3 door refrigerator was cleaned. All undated food items were discarded. The food slicer was cleaned. Food temperatures are being recorded prior to each meal service. The microwave oven was cleaned. The floor mats were removed and are no longer stored with food items. The | 07/16/2011 |

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| | Findings include:<br><br>On 06/13/11 between the hours of 11:49 a.m. 12:25 p.m. the following was observed:<br><br>1. The 3 door refrigerator was soiled with a sticky orange substance on the floor of the refrigerator.<br><br>2. A. Seven peanut butter and jelly sandwiches on a plate lacked a date. The dietary manager indicated everything should be dated and be discarded after three days.<br>B. Two plates with tomato slices without a date.<br>C. Two lettuce salads without a date.<br>D. A container of fruit cocktail without a date.<br>E. A large container of fruit cocktail dated 5/25/11.<br>F. Seven dishes of cottage cheese without a date.<br>G. Eighteen small dishes of applesauce without a date.<br>I. A container of Mandarin oranges lacked a date.<br><br>3. The food slicer was soiled with dried food debris. The dietary manager indicated it was last used the evening before.<br><br>4. Food temperatures for the breakfast meal were not recorded at 11:50 a.m. In interview with the cook, at this time, she indicated she took them but failed to record them.<br><br>5. The microwave oven was soiled on the inner surface with a sticky brown substance.<br><br>6. Two rubber floor mats were rolled up on a shelf under the prep counter. The dietary manager indicated the mats were placed on the shelf when | | gasket on the chest freezer was repaired. Plastic tubs and utensils were cleaned. The container lids were cleaned. Covers were placed over the lights above the storage area for steam table pans and back door exit. Bowls and cups were cleaned. II. Daily Sanitation Checks were completed to identify any further kitchen sanitation issues. None were identified. III. Dietary Aide #1 was reeducated on proper food handling and hand washing. Dietary cleaning schedules and Daily Rounds form were drafted and approved by QA Committee. All dietary employees will be reeducated on proper food storage and labeling, proper cleaning techniques, proper food handling, hand washing and meal time temperature recording. IV. The Dietary Supervisor or designee will conduct daily audits of food storage, food labeling, food temperature logs and sanitation of dietary department. The results of these audits will be reported to QA weekly for four weeks, monthly for two months and quarterly thereafter. V. Date of Completion: July 16, 2011 | |

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| | the floor was mopped last evening. Packages of Kool Aid and plastic bags were also stored on the shelf.<br><br>7. The gasket on the chest freezer was loose approximately 12 inches in one area and 2 inches in a second area.<br><br>8. Plastic tubs with utensils stored in them were soiled with food crumbs/debris on the inner surfaces.<br><br>9. The lids of the containers for sugar and food thickener were soiled with a sticky substance.<br><br>10. Dietary aide #1, was observed to drop margarine pats on the floor and lifted the lid of the trash can with bare hand and disposed of the margarine. She continued to prepare the trays for lunch without washing her hands.<br><br>11. The ceiling lights in the storage area for steam table pans and the back door exit lacked a cover.<br><br>12. Eleven of sixteen bowls stored as clean were soiled with food debris on the inner surfaces.<br><br>13. Eight of sixteen cups stored as clean were soiled with food debris on the inner surfaces. | | | |